STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	01	COMPL	
		155291	B. WING			01/16/	2013
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
FACIE!	/ALLEY MEADOW	6			ALLEY FARMS RD		
	1				APOLIS, IN 46214		
(X4) ID		STATEMENT OF DEFICIENCIES	D.	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
K0000	REGULATORT OF	R LSC IDENTIFTING INFORMATION)		IAU			DATE
110000							
	A Life Safety C	ode Recertification and	K000	0			
		Survey was conducted by			The creation and submission of	of	
		e Department of Health in			this Plan of Correction does no		
		n 42 CFR 483.70(a).			constitute an admission by this provider of any conclusion set		
		<b>(</b> )			forth in the statement of		
	Survey Date: 0	1/16/13			deficiencies, or of any violation	n of	
		-, - <del>-</del> -, - <del>-</del>			regulation.		
	Facility Number	r: 000188					
	Provider Number						
	AIM Number:				This provider respectfully		
	1111111110011	10020010			requests that the 2567 Plan of		
	   Surveyor: Marl	k Caraher, Life Safety			Correction be considered the		
	Code Specialist	<del>_</del>			Letter of Credible Allegation and requests a Desk Review in lieu of		
	Code Specialist				a Post Survey Review on or a		
	At this Life Safe	ety Code survey, Eagle			02/14/13.		
		rs was found not in					
	1	h Requirements for					
	_	Medicare/Medicaid, 42					
		33.70(a), Life Safety from					
	_	00 edition of the National					
		Association (NFPA) 101,					
		le (LSC), Chapter 19,					
	1	Care Occupancies and					
	410 IAC 16.2.	Care Occupanoles and					
	110 1110 10.2.						
	This one story f	acility was determined to					
		11) construction and was					
		d. The facility has a fire					
		ith smoke detection in the					
	1	all areas open to the					
		acility has battery operated					
		s in all resident sleeping					
	SHOKE GELECIOIS	o in an resident steeping					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

19NJ21

TITLE

PRINTED: 02/06/2013
FORM APPROVED
OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 01	(X3) DATE COMPL	
	. , ,	155291		LDING		01/16/	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ALLEY FARMS RD		
	ALLEY MEADOWS			INDIANA	APOLIS, IN 46214		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1110		lity has a capacity of 115		1110			5.112
		of 92 at the time of this					
	survey.						
	All arong whore	residents have customary					
		nklered. The facility has					
	-	ilding, a wooden storage					
		facility services which					
	was not sprinkle	-					
	-						
		Robert Booher, Life Safety					
	Code Specialist-Me	dical Surveyor on 01/23/13.					
	The facility was	found not in compliance					
	_	entioned regulatory					
	requirements as	evidenced by the					
	following:						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I9NJ21

Facility ID: 000188

If continuation sheet

Page 2 of 13

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291		LDING	ONSTRUCTION  01	(X3) DATE COMPI 01/16	ETED
	PROVIDER OR SUPPLIER			3017 V	ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS RD JAPOLIS, IN 46214		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
K0048 SS=F	all patients and for event of an emery Based on record interview; the fact written fire safet to the activation smoke detectors resident sleeping requires a written fire safety plan s following:  (1) Use of alarms: (2) Transmission department (3) Response to a (4) Isolation of following: (4) Isolation of following: (5) Evacuation of (5) Evacuation of (7) Preparation of evacuation (8) Extinguishmore This deficient provided in the provided in t	plan for the protection of or their evacuation in the gency. 19.7.1.1 review, observation and cility failed to develop a y plan for staff response of battery operated installed in 61 of 61 grooms. LSC 19.2.2.2 in health care occupancy hall provide for the sealarms are fire fimmediate area f smoke compartment of floors and building for ent of fire actice could affect all and visitors.	K00	048	It is the practice of this provice ensure there is a written plar protection of all patients and their evacuation in the event emergency. 1. The Disaste Action Plan for the facility was updated to include staff resp to the activation of battery operated smoke detectors installed in each resident sle room by the Execuitve Direct 2. All residents have potentiated be affected by this deficient practice. 3. The Disaster Action for the facility was updated by the Execuitve Director. Ald re-educated on the action fire plan for the facility by the Maintenance Director by 02/14/13. 4. Disaster Traini will be provided to staff quarted by the SDC/designee. The Executive Director will review the Disaster Action Plan annuto ensure accuracy.	for for of an r s sonse eping or. Il to staff e eng erly	02/14/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 19NJ21

Facility ID: 000188

If continuation sheet

Page 3 of 13

PRINTED: 02/06/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	LDING	NSTRUCTION  01	(X3) DATE COMPL 01/16/	ETED
NAME OF F	PROVIDER OR SUPPLIEF			DDRESS, CITY, STATE, ZIP CODE		
EAGLE V	ALLEY MEADOWS	8		APOLIS, IN 46214		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	battery operated in each resident observations wit the Housekeepin of the facility from p.m. on 01/16/13 detectors were in sleeping room. It ime of record reacknowledged the safety plan did not the activation	conse to the activation of smoke detectors installed sleeping room. Based on h the Administrator and ag Manager during a tour om 11:35 a.m. to 1:50 g, battery operated smoke installed in each resident based on interview at the eview, the Administrator ine facility's written fire of include staff response of battery operated in resident sleeping				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 19NJ21

Facility ID: 000188

If continuation sheet Page 4 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2)			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155291	B. WIN		<del></del>	01/16/	2013
			B. (/ 11 (		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ALLEY FARMS RD		
EAGLE V	ALLEY MEADOWS	3			APOLIS, IN 46214		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG K0050 SS=F	NFPA 101 LIFE SAFETY CO Fire drills are held under varying cor on each shift. Th procedures and is of established rou planning and come only to competent to exercise leaded conducted between announcement maudible alarms.  1. Based on recor the facility failed conducted on the shift for 1 of 4 qu practice could aff and visitors.  Findings include  Based on review Report" document Administrator du 9:30 a.m. to 11:3 documentation of the second and th quarter of 2012 aff the fourth quarter available for review Administrator acc documentation of the aforemention	DDE STANDARD d at unexpected times inditions, at least quarterly e staff is familiar with s aware that drills are part utine. Responsibility for ducting drills is assigned it persons who are qualified riship. Where drills are en 9 PM and 6 AM a coded ray be used instead of 19.7.1.2 ord review and interview, it to document fire drills e first, second and third uarters. This deficient fect all residents, staff  of "Monthly Fire Drill intation with the uring record review from is a.m. on 01/16/13, if a fire drill conducted on inird shift for the first and on the first shift for or of 2012 was not iew. Based on interview cord review, the eknowledged if fire drills conducted on and shifts was not	K00		It is the practice of this provide ensure fire drills are held at unexpected times under varyir conditions, at least quarterly of each shift. The staff is familiar with procedures and is aware drills are part of the establisher outine. Responsibility for planning and conducting drills assigned only to competent persons who are qualified to exercise leadership. Where drare conducted between 9 pm and 6 am a coded announcement may be used instead of audiblicational auditorial aid. The Maintenance Director was re-educated on the fire drill shift/time stagger worksheet by the Executive Director by 02/14/13. 2. All residents have the potential to affected by this deficient practical 3. Fire drills will be performed once per shift per quarter by the Maintenance Director and or designee. 4. Executive Director will reveiw the monthly fire drill reports quarter to the state of the potential to a state of the performed once per shift per quarter by the Maintenance Director and or designee. 4. Executive Director will reveiw the monthly fire drill reports quarter to the performed once per shift per quarter by the Maintenance Director and or designee. 4. Executive Director will reveiw the monthly fire drill reports quarter to the performed once per shift per quarter by the Maintenance Director and or designee. 4.	er to ng n that d is rills and e he be ice.	DATE  02/14/2013
	available for revi	iew.			to ensure the drills are held on	-	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 19NJ21

Facility ID: 000188

If continuation sheet

Page 5 of 13

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	01	COMPL	ETED
		155291	B. WIN			01/16/	2013
C OF P					ADDRESS, CITY, STATE, ZIP CODE	<b>-</b>	
NAME OF P	PROVIDER OR SUPPLIER	L		3017 V	ALLEY FARMS RD		
	ALLEY MEADOWS	3		INDIAN	APOLIS, IN 46214		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA <sup>*</sup> DEFICIENCY)	ΓΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
					each shift.		
	3.1-19(b)						
		ord review and interview,					
	the facility failed						
		the fire alarm signal for					
		eted prior to 9:00 p.m. on					
		for 1 of 4 quarters. LSC					
	19.7.1.2 states fi	re drills in health care					
	occupancies shall	ll include the					
	transmission of t	he fire alarm signal and					
	simulation of em	nergency fire conditions.					
	This deficient pr	actice affects all					
	residents, staff a	nd visitors.					
	Findings include	:					
	Based on review	of "Monthly Fire Drill					
	Report" docume	ntation with the					
	Administrator du	aring record review from					
		35 a.m. on 01/16/13,					
		or the second shift fire					
	drill conducted of	on 04/17/12 at 5:15 p.m.					
		ransmission of the fire					
	alarm signal. Th	ne documentation for the					
	_	fire drill recorded "No" in					
		Irill record statements of					
	_	n to activate the fire					
		nd "was it verified that the					
	-	ce received the alarm."					
	_	ew at the time of record					
		inistrator acknowledged					
	•	of the second shift fire					
		on 04/17/12 at 5:15 p.m.					
	dilli colludeted (	0					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I9NJ21

Facility ID: 000188

If continuation sheet Page 6 of 13

PRINTED: 02/06/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155291  A. BUILDING B. WING	COMPLETED 01/16/2013					
NAME OF PROVIDER OR SUPPLIER  EAGLE VALLEY MEADOWS  STREET ADDRESS, CITY, STATE, ZIP OF STATE, ZIP	3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CO PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMDUCTION					
did not include transmission of the fire alarm signal.						
3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 19NJ21

Facility ID: 000188

If continuation sheet

Page 7 of 13

PRINTED: 02/06/2013
FORM APPROVED
OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	JLTIPLE (	ONSTRUCTION 01	r ´	3) DATE SURVEY COMPLETED	
THINDTEIN	or conduction	155291	A. BUII			01/16/		
		.00201	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 0.		
NAME OF P	ROVIDER OR SUPPLIER				/ALLEY FARMS RD			
EAGLE V	ALLEY MEADOWS	3			NAPOLIS, IN 46214			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
		LSC IDENTIFYING INFORMATION)	+	IAG	DEFICIENCE		DATE	
K0130 SS=E	NFPA 101 MISCELLANEOU OTHER LSC DEF Based on record interview; the fac care and mainten doors was in acce LSC 4.5.7 requir or system which compliance with Code, such device shall thereafter b Code exempts su 80, 1999 Edition Doors and Fire V 15-2.4.3 requires sliding and rollin inspected and test proper operation Resetting of the re be done in accord manufacturer's in record shall be m made available to jurisdiction. This affect 50 resident the Main Dining  Findings include	ESCIDENTIFYING INFORMATION)  SECULENCY NOT ON 2786 review, observation and cility failed to ensure the nance of 1 of 1 rolling fire ordance with NFPA 80. The second requipment is required for the provisions of this re, equipment or system to maintenance. NFPA to the Standard for Fire Windows, Section all horizontal or vertical regiment of the steel annually to check for and full closure. The release mechanism shall dance with the national and shall be to the authority having the steel annually to check for an annual to the authority having the steel and visitors in Room.	K01	TAG		er to ince 1. I to or as	02/14/2013	
	a.m. on 01/16/13	, documentation of an						
	annual rolling fir	e door inspection was						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 19NJ21

Facility ID: 000188

If continuation sheet

Page 8 of 13

PRINTED: 02/06/2013
FORM APPROVED
OMB NO. 0938-0391

NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	LDING	NSTRUCTION  01	(X3) DATE : COMPL 01/16/	ETED
PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, STATE, ZIP CODE ALLEY FARMS RD APOLIS IN 46214		
summary s (EACH DEFICIENT REGULATORY OR not available for observation with the Housekeepint of the facility from the facility from the Main Dining tag indicating the inspection of the performed in Definiterview at the observation, the acknowledged it year since the minspection was of	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) Teview. Based on the Administrator and ag Manager during a tour om 11:35 a.m. to 1:50 B, the rolling fire door bening from the kitchen to a Room had an inspection the most recent annual the rolling fire door was been been more than one cost recent annual of the rolling fire door was beek for proper operation		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I9NJ21

Facility ID: 000188

If continuation sheet

Page 9 of 13

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	01	COMPL	ETED
		155291	1			01/16/	2013
			B. WIN		ADDRESS OF A STATE OF SORE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ALLEY FARMS RD		
EAGLE V	ALLEY MEADOWS	5		INDIAN	APOLIS, IN 46214		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
K0144	NFPA 101						
SS=F	LIFE SAFETY CO	DDE STANDARD					
	Generators are in	spected weekly and					
	exercised under l	oad for 30 minutes per					
	month in accorda	nce with NFPA 99.					
	3.4.4.1.						
	1. Based on reco	ord review and interview,	K01	44	It is the practice of this provide	r to	02/14/2013
	the facility failed	l to ensure a monthly load			ensure generators are inspect		
	_	gency generator was			weekly and exercised under lo	ad	
		of 12 months using one			for 30 minutes per month in		
		•			accordance with NFPA 99. 1.		
		wing methods: under			The Maintenance Director was re-educated on weekly and	•	
		rature conditions, at not			monthly generator testing and	the	
	less than 30% of	the Emergency Power			preventative maintenance	uic	
	Supply (EPS) na	meplate rating, or loading			schedule by the Executive		
	that maintains th	e minimum exhaust gas			Director. 2. All residents have	е	
		recommended by the			the potential to be affected by		
	_	Chapter 3-4.4.1.1 of NFPA			deficient practice. 3. The		
		•			Maintenance Director will		
	•	thly testing of generators			complete the monthly load test		
		gency electrical system to			and weekly inspection checklis	st	
	be in accordance	with NFPA 110.			according to the facility		
	Chapter 6-4.2 of	NFPA 110 requires			preventative maintenance		
	generator sets in	Level 1 and Level 2			schedule. 4. The Executive Director will review the		
	_	ercised at least once			Preventative Maintenance		
		inimum of 30 minutes,			Schedule monthly to ensure		
	•	-			completion.		
	_	following methods:					
	*	ng temperature conditions					
		n 30 percent of the EPS					
	nameplate rating						
	b. Loading that n	naintains the minimum					
	exhaust gas temp						
		the manufacturer.					
	_						
		e of day for required					
	_	lecided by the owner,					
		operations. NFPA 99,					
	3-5.4.2 requires a	a written record of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I9NJ21

Facility ID: 000188

If continuation sheet Page 10 of 13

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA				ĺ
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
		155291	B. WIN	G		01/16/2013
NAME OF B	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			3017 V	ALLEY FARMS RD	
	/ALLEY MEADOWS				APOLIS, IN 46214	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE	DATE
		ormance, exercising				
	period and repair	rs shall be regularly				
	maintained and a	available for inspection				
	by the authority	having jurisdiction. This				
	deficient practice	e could affect all				
	residents, staff a					
	Findings include	:				
		CHE				
	Based on review					
		ly Exercise/Monthly				
		documentation with the				
	Administrator du	uring record review from				
	9:30 a.m. to 11:3	35 a.m. on 01/16/13,				
	monthly load tes	t documentation for				
	<u>-</u>	vas not available for				
	1	n interview at the time of				
	record review, th					
		ocumentation of monthly				
	_	-				
		entation for February				
	2012 was not av	ailable for review.				
	3.1-19(b)					
	2. Based on reco	ord review and interview,				
	the facility failed	to ensure a complete				
		f weekly inspections of				
		ries for the emergency				
	_	aintained for 3 of 52				
	~	3-4.4.1.3 of NFPA 99				
	1					
	requires storage					
		essential electrical				
	systems shall be	inspected at intervals of				
	not more than 7	days and shall be				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 19NJ21

Facility ID: 000188

If continuation sheet Page 11 of 13

PRINTED: 02/06/2013
FORM APPROVED
OMB NO. 0938-0391

	of Correction identification number:  155291	A. BUILDING  B. WING	01	COMPLETED 01/16/2013
	PROVIDER OR SUPPLIER  /ALLEY MEADOWS	3017 V	ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS RD APOLIS, IN 46214	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.  Findings include:  Based on review of "Emergency Generator-Weekly Exercise/Monthly Load Test Log" documentation with the Administrator during record review from 9:30 a.m. to 11:35 a.m. on 01/16/13, weekly emergency generator starting battery inspection records for the three week period of 02/21/12 through 03/07/12 was not available for review. Based on interview at the time of record review, the Administrator acknowledged documentation of weekly battery inspections for the three week period of 02/21/12 through 03/07/12 was not available for review.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I9NJ21

Facility ID: 000188

If continuation sheet

Page 12 of 13

PRINTED: 02/06/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:  155291	A. BUILDING  B. WING		COMPLETED 01/16/2013
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
	ALLEY MEADOWS		3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI TAG DEFICIENCY)		(X5) COMPLETION
TAG			IAG	DATE DATE	
	3.1-19(b)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 19NJ21

Facility ID: 000188

If continuation sheet Page 13 of 13